TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 OF DALLAS

MFDR Tracking Number
M4-17-3764-01

MFDR Date Received
August 22, 2017

Respondent Name
INDEMNITY INSURANCE COMPANY

Carrier's Austin Representative
Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were denied per EOB based on the findings of a review organization... It is our position that Sedgwick CMS has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to [injured employee]."

Amount in Dispute: $343.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 30, 2017. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 12, 2017 and April 13, 2017	90837 and 96151	$343.29	$206.73

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedure for resolving medical necessity disputes.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization

Issues

1. What are the denial reason(s) raised by the insurance carrier during the bill review process?
2. Did the requestor obtain preauthorization for CPT Code 90837 rendered on April 12, 2017?
3. What is the applicable rule for determining reimbursement for the disputed service?
4. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT Code 96151 rendered on April 13, 2017. The insurance carrier denied the disputed service with denial reason code "216 – Based on the findings of a review organization."

   The respondent did not submit a response to MFDR for consideration. The requestor states in pertinent part, "CPT Code 90837 was preauthorized... therefore it is deemed medically necessary. Also, CPT code 96151 does not require preauthorization and is not global with any other code."

   The service in dispute, CPT Code 96151 rendered on April 13, 2017 was denied by the workers' compensation carrier due to an unresolved medical necessity issues. Documentation provided by the parties indicates that the insurance carrier denied payment to the requestor due to an unresolved medical necessity issue. The carrier's explanation of benefits was timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

   The service in dispute, CPT Code 96151 rendered on April 13, 2017 contains an unresolved medical necessity issue. For that reason, this matter is not eligible for adjudication of a medical fee under 28 Texas Administrative Code §133.307.

   The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   The Division finds that CPT Code 96151 rendered on Aril 13, 2017 is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

2. The requestor billed CPT Code 90837 on April 12, 2017. The insurance carrier denied the disputed service with denial reason code "216 – Based on the findings of a review organization."

   The requestor indicates that preauthorization was obtained for CPT Code 96151 rendered on April 12, 2017 and references preauthorization number 2312540. The Division therefore finds that preauthorization was obtained for the disputed service.

   28 Texas Administrative Code §134.600(c) (1) (B) states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

3. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   Procedure code 90837, rendered on April 12, 2017, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1.015 is 3.045. The practice expense (PE) RVU of 0.46 multiplied by the PE GPCI of 1.012 is 0.46552. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.77 is 0.0847. The sum of 3.59522 is multiplied by the division conversion factor of $57.50 for a MAR of $206.73.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $206.73. Therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $206.73.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $206.73 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 15, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.